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Bold thinking for better health

Direct payments

Creating the conditions for choice and control

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Executive summary

Why direct payments matter

Direct payments are monetary payments made by local authorities to people who qualify for publicly funded adult social care under the 2014 Care Act. In principle, they give people more choice, control and flexibility over how their care and support is arranged, and for many people, they are life changing. Direct payments can support more tailored, meaningful and independent lives than traditional commissioned services.

However, direct payments are not working as well as they should. There is a persistent gap between policy ambition and reality, and take-up of direct payments is low and declining. There is also wide variation in uptake between local authorities.

Direct payments are a longstanding policy priority in England, and their uneven implementation raises wider questions about whether the adult social care system is genuinely enabling choice and control.

What this research aimed to understand

This research looked at why direct payments are not being taken up by large numbers of people across England, and why there is such a high variation in uptake across local authorities. Through interviews in five local authority areas, we aimed to understand what can be done to improve the experience for those using direct payments, as well as for staff who deliver them.

What we found

For many people who draw on social care, direct payments are highly valued. But people's experiences are highly uneven. Some feel trusted, supported and able to use their direct payment creatively, in a way that suits their lives. Others described burdensome administration, weak support, infrequent reviews, and anxiety about getting things wrong.

At the same time, local authorities are putting in substantial efforts to increase the quality of direct payments, as well as the number of people who use them. We share examples of practical changes and organisational culture shifts designed to improve the implementation of direct payments. These include training and support for social work practitioners (sometimes referred to as 'social workers'), designing budgets in ways that better support creative and flexible direct payments, ensuring appropriate financial assurance, and developing a market that gives people better choices.

Our research shows how direct payments are being asked to work in an adult social care system that is not consistently designed to support them. For example, social work practitioners are being trained to deliver personalised care but often operate within wider financial and

workload systems that are in conflict with the features of direct payments. This means that training and support for frontline staff may not, on their own, increase the uptake of direct payments.

There are also fundamental tensions built into the care ecosystem in England that limit local leaders' ability to shape direct payments. Our research suggests that even well-intentioned and often intensive efforts to improve practice can be constrained by wider system conditions. This means that improvement efforts do not always translate into higher uptake of direct payments.

Variation in the take-up of direct payments across local authorities cannot be explained simply by how hard local authorities are trying. Reported uptake figures do not necessarily show whether direct payments are of high quality, or whether people using them have meaningful choice and control. In some cases, the numbers themselves can be misleading. We found no obvious relationship between a local authority's reported efforts to improve direct payments and the number of people using them.

Local authorities operate in different local contexts, with different populations and different models for delivering direct payments. Each also has its own organisational culture and leadership. Understanding how these impact direct payments is key, but provides insufficient insight into why uptake remains low, and practice so inconsistent. Based on our findings, we suggest that the design and maintenance of the national adult social care system does not support local authority efforts to improve the quality of direct payments – and at times even undermines them.

What needs to happen next?

Improving direct payments will require more than better implementation alone. Existing guidance and examples of good practice remain important, but they are unlikely to be enough on their own. Direct payments are being asked to succeed in a system that is not designed for them, and so new approaches may be required to fix the fundamental problems with direct payments.

We provide recommendations around three different frames, and look at what national and local stakeholders can do with regard to each.

Improve the current system of direct payments

This will require consistent implementation of good practice, effective support for people wanting to use a direct payment, stronger leadership, clearer accountability, better evidence on what works, new data, and a more explicit systems approach to supporting choice and control in adult social care.

Improve the delivery model for providing financial choice and control

National government should consider whether an alternative approach could deliver the degree of choice and control that many people want. Countries such as Germany and Australia offer alternative models where people in need of long-term care support receive a budget based on

their level of assessed need but have few, if any, restrictions on how they spend that money. Such an approach changes the relationship between the individual and the state, with a shift of power towards the individual. It would, however, involve a very significant change for the English social care system and to the role of local authorities, with much less scrutiny of public funds.

Take a broader approach to improve personalisation, choice and control for everyone

Direct payments have been in use in adult social care and support in England since the mid-1990s and they remain the government's preferred mechanism for personalised care and support. But direct payments are not right for everyone, and they should not be the only route for people to access high levels of choice and control. An approach that focuses on improving choice and control for everyone explicitly supports improvements in the quality of direct payments – but not necessarily uptake.

Part 1: Context

01 Introduction

A brief history of direct payments

Direct payments are monetary payments made by local authorities to people who qualify for publicly funded adult social care under the 2014 Care Act. The policy intention is that because people receiving direct payment can purchase their own services and other support, they should therefore have greater control over the care they receive.

Direct payments have their origin in the development of independent living schemes in the 1980s, which allowed disabled people to live in the community rather than in institutions. In England, these were difficult to establish because it was not possible, under the 1948 National Assistance Act, for local authorities to offer people cash to arrange their own support.

In 1989, the British Council for Disabled People began a campaign to overturn this restriction, which led to the 1996 Community Care (Direct Payments) Act, allowing local authorities to provide direct payments to people aged 18–65 who had been assessed as needing community care services. This was later amended to include older people as well.

However, local authorities could opt not to provide direct payments if they wished until the Health and Social Care Act (2001), which required them to provide direct payments to any eligible person requesting one.

The Care Act (2014) further enshrined direct payments by making it a legal requirement for the local authority to create a care and support plan for each person, including a 'personal budget' – the amount of money the local authority would provide to meet the person's eligible care needs. This personal budget could be received in three ways.

1. A managed account, in which the local authority holds the individual's personal budget and commissions or provides services for them.
2. A 'third party' managed account, in which another party – often a provider – holds the individual's personal budget (this is often known as an individual service fund).
3. A direct payment, in which a person receives some or all of their personal budget as a monetary payment to spend on meeting their assessed needs. This type of payment is the focus of this report.

However, since 2014, the usage of direct payments has not taken off in the way the Act intended. In 2023/24, around 9,400 fewer people used direct payments than in 2015/16. Overall, just 25% of people (37% of working-age adults and 14% of older people) drawing on adult social care were using direct payments, down from 28% in 2015/16 (The King's Fund 2026).

Although data from 2024/25 cannot be compared to previous years due to a change in the data source and methodology, 24.5% of people received a direct payment. More working-age adults than older people used a direct payment: 35.5% of those aged 18–64 received a direct payment, compared with 13.6% of those aged 65 and over (DHSC 2025a).

There is regional variation in uptake of direct payments. Overall, the highest proportion was in the East Midlands (33.6%) while the lowest was in the North East (19.8%). Among working-age adults, Yorkshire and the Humber (42.4%) had the highest proportion receiving a direct payment, compared with London (32.1%) and the South West (32.1%). Among older people, the East Midlands (20.4%) had the highest proportion of direct payments, while the North East had the lowest (8.2%) (DHSC 2025a).

There is also local variation. Three local authorities (Gloucestershire, Wirral and Portsmouth) reported fewer than 10% of people receiving direct payments, while seven local authorities (Rotherham, Herefordshire, Leicester, Stockton-on-Tees, North Lincolnshire, Lincolnshire and Enfield) reported more than 40% of people receiving direct payments. One local authority (the Isle of Wight) reported more than 50% of people receiving direct payments (DHSC 2025b).

Aims of this research

The Department of Health and Social Care (DHSC) commissioned this research. It is designed to deepen understanding of direct payments in England.

We were asked to look at why direct payments are not being taken up by large numbers of people across England, and why there is such high variation in uptake across local authorities.

To answer these questions, we carried out qualitative research in five local authorities, selected to provide a range of population and geographic characteristics, and different rates of uptake of direct payments. We interviewed local authority staff and people who use direct payments between July 2025 and February 2026. Importantly, we found that most, if not all, of our sites were in the middle of a transformational process in relation to direct payments. This means that our research reflects a snapshot in time and, as such, we recognise that participants' experiences provide valuable learning, rather than an up-to-date reflection of their current position. Full details of how we undertook this research can be found in the Annex.

It is important to note that this was not an evaluation. We were interested in what key stakeholders, including people who use direct payments, think about the current provision and support for direct payments, and what could be done to improve both uptake and experience. The framing of the interviews was governed by the research brief but also by a desire not to simply replicate existing work on this subject.

Building on existing research and good practice

Research on direct payments since the Care Act 2014, and even earlier, has been remarkably consistent in the themes it identifies. It highlights the barriers people face in using direct payments as well as the challenges local authorities experience in implementing them (*see* Tawodzera 2025; Watson 2025; Glasby and Littlechild 2016; Hasler and Marshall 2013; Fernández *et al* 2007; Watson n.d.). What also stands out is the value people place on direct payments and their ability to offer greater control, and more tailored and meaningful support.

The key themes that have emerged over the past decade or so help to explain why uptake is low and uneven across the country. These include the burden placed on people using direct payments in terms of low awareness, complexity, financial scrutiny, and the responsibilities of being an employer. The research also highlights the barriers local authorities face in terms of governance, financial oversight, funding, a culture of risk aversion, and a lack of confidence and awareness among their staff. The fragility of the personal assistant (PA) workforce and the challenges people face in recruiting a PA also feature (Skills for Care 2026; Think Local Act Personal (TLAP) 2022). What emerges from the literature is that the issues faced by people using direct payments and by those working in local authorities to implement them are often the very same – workforce challenges, bureaucracy, fear, and lack of awareness.

The research also suggests that use of direct payments in England is also broadly consistent with that undertaken in Northern Ireland (Burns *et al* 2025), Wales (Audit Wales 2022) and Scotland (MacIntyre and Stewart 2026; Riddell *et al* 2006). Together, these highlight persistent challenges in implementation, including inconsistent practice, limited awareness, workforce constraints, and ongoing inequalities of access for groups that have been historically less well-served, including people with learning disabilities or mental health problems, and some ethnic minority communities.

In addition, there is no shortage of good practice and guidance on what local authorities can do to improve direct payments. Evidence from TLAP's national insight reports and learning resources (TLAP 2026), Social Care Institute for Excellence (SCIE) practice reviews, and from the Association of Directors of Adult Social Services/Local Government Association (ADASS/LGA) shows that direct payments continue to offer greater choice, flexibility and personalisation when implemented well. Recent national initiatives led by TLAP, the LGA (LGA 2025), as well as local ADASS networks (for example, the West Midlands) have emphasised reflective practice, peer learning, and improving practitioner leadership as well as embedding co-production.

The literature on direct payments over the past two decades suggests a persistent gap between the policy ambition and implementation. In that sense, direct payments have often been easier to champion in theory than to deliver consistently in practice.

Of course, direct payments sit in a wider policy and funding context. The Care Act 2014 sets out a broadly permissive, outcomes-focused approach to direct payments, allowing flexibility in how they are used, as long as they meet an assessed need. However, this flexibility operates within

a broader social care system that continues to face significant financial constraints and rising demand, with local authorities balancing competing pressures on limited resources. At the same time, the Act's emphasis on local discretion and individual tailoring can contribute to ambiguity in interpretation and variation in practice. This can leave both practitioners and the people drawing on care and support having to navigate uncertainty around what is permissible and achievable, with local approaches reflecting differing thresholds, market conditions and organisational cultures as much as national policy.

About this report

The report is structured as follows.

In Part 1, we draw on interviews and focus groups with people from our five case study areas who either use a direct payment or manage one on behalf of a family member. Their experiences illustrate the complexity of using direct payments and what makes them attractive to people who draw on social care. In Part 2, we take stock of what local authorities from the five case study sites have told us, drawing on the practice and experiences of those working across different functions. We explore what is driving the variation in both perceptions and practice when it comes to direct payments. Part 3 discusses the implications of our findings and explores what might explain the variation in uptake. Finally, in Part 4, we invite national and local leaders to reflect on what they could do to improve both the quality and quantity of direct payments.

02 What do people who use direct payments think about them?

The people we spoke to were keen for their views to be heard by local and national government. Indeed, several individuals said, without any prompting, that they would welcome opportunities to share their experiences. They had ideas and insights that they believed could be used to improve the way direct payments were implemented and services procured.

However, though almost all were keen advocates of direct payments (at least in principle), the views they expressed often differed widely. We found little common experience between and within the five case study sites:

- Some felt the paperwork required was 'no bother', whereas others found that it took them hours to compile what they felt were unnecessarily detailed accounts.
- Some were supported to use a direct payment to live the life they wanted to the full and feel well connected to their community, whereas others felt they had no choice and their options on how they used their budget were very restricted.
- Some had 'amazing' social work staff to support them, whereas others hadn't had a review in years and had no point of contact.

We have tried to capture this variation in the findings below. We interviewed a small sample of people who use direct payments. Their views may not be representative but add vital insight into how direct payments are used in practice.

Direct payments are life-changing for many people

Everyone we spoke to (bar one) who was either using a direct payment or managing one on behalf of a family member wanted to keep their direct payment. Despite the problems people experienced, direct payments were felt to be a much better option than the alternative care organised by a local authority. Giving up choice and control was not something they were willing to contemplate, even if the decision to use a direct payment could often feel like the 'least worst' option available.

> *Generally speaking, apart from not being able to find people sometimes… I can't imagine for me an alternative system that would work as well.*

Although people's experiences varied considerably across, and sometimes within, a local authority, they were consistent in wanting their voice to be heard. Many people had developed substantial expertise in using direct payments and were often supporting others to understand and manage them. Below, we outline the key themes that emerged when people discussed

their decision to use a direct payment and the support they received to manage it. These experiences highlight both the wide variation in practice and the need for improvement.

People want to feel in control, but often do not feel they have the flexibility and control they would like

If somebody said 'is direct payments flexible?', personally my answer would be no.

Having your own budget to manage – and being able to choose the support you want, when you want – is one of the key principles of direct payments. Yet many people reported that they did not have the flexibility or control they would like.

Although a few individuals were using their direct payment to access sport, art activities or education, most were either employing a PA or an agency. For some, restrictions on what they could spend the direct payment on were not a problem – they only wanted to use their budget to employ a PA, for example. However, others told us that they had only been awarded a direct payment on the condition that they used it to employ a PA.

Across the five local authorities – and sometimes within the same local authority – people using direct payments reported quite different experiences of whether, and how far, they could use their budget flexibly. Some people were able to flex their budget to suit their needs – for example, to 'bank' hours from one week and use more the following week. Others said that they lost any hours they didn't spend. Some were given a contingency to cover emergencies, whereas others were not told they had any contingency.

We also heard that some people had large amounts of unspent money in their accounts (for example, over £5,000), often over a period of several years, and it was unclear whether they could spend it. Some local authorities never claimed back this money; others had any excess balance removed regularly. This 'extra' money was not necessarily because of a generous contingency allocated by the local authority. Sometimes it was a result of people underspending on their budget and/or being unable to recruit a PA or find an appropriate agency, or receiving a large retrospective payment.

When it came to contingencies, we again found a very mixed picture. Some people were aware that a contingency was included in their budget and knew they could spend it if they had an emergency. Others had no knowledge of this and often spent their own personal funds to find cover for a PA at short notice, for example.

People want to feel trusted but some feel there is an inappropriate level of financial scrutiny

People who used a direct payment had different views about what they thought was an appropriate level of intrusion when it came to financial scrutiny. There is recognition that local

authorities need to keep themselves accountable for how they spend public money. But we also heard from individuals who resisted what they perceived to be over-intensive scrutiny. Some people felt that this disproportionate amount of inspection relative to the sums involved created an atmosphere of fear among direct payment users. They also thought that the reaction to mis-spending was, at times, over the top – for example, it was reported that one man had mis-spent his direct payment on a flat screen TV, with one interviewee saying, 'Honest to God, you'd think they'd flown to the Bahamas.'

In some areas, people had been moved to pre-paid cards/accounts and some appreciated the greater transparency and access this gave them to their accounts. In one area, this move had come with agreement that no money would be removed from a person's account without checking with them first. Although people accepted the need for scrutiny, they resented the significant time it took, the costs associated with documenting spend, the mistakes made by payroll providers, and the level of detail that was sometimes requested to justify the spend.

People want more support

Few people felt well-supported by the local authority to manage their direct payment. Many described having no named contact and needing to go back through a general enquiry route once their case was closed.

> *I thought that was just how you got to care… There was no… no support on anything. It was so we had to get a mortgage a couple of years ago. That was easier… The whole process was very difficult. But the council never said there was any other options, they just said that's how it happened*.

Support in the form of information, advice and guidance or employment services that are commissioned from large national organisations was heavily criticised, with people reporting repeated mistakes and errors. In contrast, support from local disabled people's organisations was valued more highly, although in some areas commissioned provision was limited to narrow functions rather than broader advice. Several people also felt that social work practitioners had limited knowledge about direct payments.

In the absence of reliable support, some people had developed their own expertise in pensions and payroll, and administration and bookkeeping, often drawing on peer networks.

One area where everyone agreed they needed more support was PA recruitment. It can take months to find a PA at the rates offered, and people described very mixed experiences of the amount and quality of help available to recruit and appoint a PA – from social work practitioners and direct payment advisers to local and national support providers.

To reduce the burden of employing staff, some people used direct payment support providers. Depending on the local authority, people could either choose their own payroll provider or were required to use a council-approved provider.

Some people showed us reams of paperwork they had to digitise and send to finance teams to account for their spending. Several felt that this administrative workload was not recognised or resourced – for example, through additional funds for stationery or equipment needed solely to administer the direct payment.

The time and effort required to demonstrate appropriate use of a direct payment felt excessive to some people, and disproportionate to the level of risk. One woman explained:

> *My daughter also has a little bit of money for transport because there was some transport issues in the area. So there's a little bit of money. I have a receipt book that's signed by whoever is being paid for the transport. I have to photograph all of those now and send all of that in. And then they asked me to send copies of everybody's payslip and I refused.*

People want to be seen and heard, but some feel that reviews are infrequent and ineffective

Some interviewees had not had a review for years, whereas others spoke about them being done by staff who they did not know, including agency social workers contracted to do the reviews from outside the local authority. Rather than focusing on people's needs, some people were also left in fear that their budgets would be cut by reviews that felt financially led.

Infrequent care reviews also meant that people did not consider local authorities to have a deep understanding of how well a person's budget met their needs. For example, one woman suggested the local authority had no idea that her underspend was a result of her doing all the holiday cover, or another having to manage the budget so she could double-pay a newly recruited PA to shadow alongside the existing PA. We felt a sense of abandonment among several people who had been using direct payments, often for long periods:

> *I think it would be nice if someone kept in contact with us more frequently and just said, you know, 'Do you want to review? Is everything working all right? Is there anything else we can do?' Because that kind of… that doesn't really happen.*

There were some examples of excellent relationships between local authority staff and people using direct payments – but many described frustration with the lack of contact, support and knowledge. One man requested an increase in his budget to cover the increase in the minimum wage, and was met with a response of 'Do you really have to pay the minimum wage?'

Part 2: What did we learn from local authorities?

03 Local authorities are making real efforts to improve direct payments

Interviewees in local authorities were not short of initiatives they thought had improved people's experiences of using and delivering direct payments, or of further ideas. Our job wasn't to evaluate the success of these actions, which means that we cannot recommend them. Nevertheless, we share below what others have said works for them, in their local context, and as part of their wider strategy to deliver high-quality direct payments. Some of the ideas are contradictory and others are untested. However, all are based on a shared aim: to strengthen genuine direct payments rather than simply increase uptake. These initiatives provide important balance to the rest of this report, which focuses on why variation in uptake exists.

Training and development

Ideas and activities we heard about:

- offering training to a wide range of staff, not only social work practitioners, including hospital-at-home teams
- where training cannot be mandatory, making it expected, visible and reported on
- working with user-led organisations, involving people with lived experience, and drawing on the history of direct payments and the independent living movement from which they emerged
- focusing training on outcomes rather than services: staff are now saying, 'okay, these are the outcomes this person wants to achieve and that might be around making more friends, feeling confident to go to the shops independently, or learning to cook a meal for their family'.

Normalising direct payments

Ideas and activities we heard about:

- after training, giving social work staff a QR code they can keep on their phone, linking to a short video that explains direct payments in simple terms to people using services
- reintroducing home visits by direct payment advisers, or asking them to accompany social work practitioners
- running weekly direct payment cafés with direct payment and audit teams: an open, informal space where practitioners can discuss cases, raise questions and get support before going to a formal panel
- investing in principal social worker and principal occupational therapist roles.

- avoiding a blame culture: focusing on giving support when things go wrong to unpick the problem, sort out how to fix it, and put it back together again.

Co-production and peer support

Ideas and activities we heard about:

- putting co-design at the centre of service development
- designing the ‘front door’ carefully so that early conversations support informed choice
- using peer review-style cafés to share cases, outcomes and learning: ‘this person has had a direct payment, this was the situation, this was the outcome’
- creating direct payment peer groups and meeting regularly with people with lived experience to hear direct feedback.

Routes in from commissioned care

Ideas and activities we heard about:

- working with discharge teams so that people can begin on commissioned care and move to a direct payment over time
- setting up split packages from the outset so that people can use commissioned care for personal care and direct payments to cover wellbeing needs
- using staged handovers, with PAs shadowing commissioned service staff before gradually taking over support
- using hospital discharge and reablement as opportunities to discuss care options and aspirational outcomes, especially for people entering adult social care for the first time.

Support for a mixed market

Ideas and activities we heard about:

- supporting people to use a mix of direct payments and commissioned care
- using direct payments for transport, particularly in rural areas, where they can be more flexible and cost-effective than local authority-arranged services
- using direct payments for equipment and digital support where appropriate
- considering digital services such as subscriptions to British Sign Language (BSL) video services
- shifting oversight from high-cost packages to high-risk arrangements
- offering support to self-funders as well as local authority-funded users.

Strengthened finance and processes

Ideas and activities we heard about:

- recording and reviewing why people stop using direct payments
- appointing a lead who can mediate disputes, unblock decisions and resolve problems quickly – one local authority reported that this approach was leading to more creativity and flexibility, and fewer requests for management intervention, suggesting that the process was becoming easier
- embedding the direct payment team within social work teams, including by sharing office space
- locating finance staff within adult social care
- prioritising regular reviews for people using direct payments so that budgets keep pace with rising costs and support remains stable
- bringing together commissioners, contract managers, finance staff and direct payment teams to tackle barriers collectively.

Rates and frameworks that support choice

Ideas and activities we heard about:

- avoiding setting different rates for commissioned care and direct payments, and instead varying rates by complexity and rurality
- giving social work staff a budget range, with PA rates at the bottom and framework rates at the top, to make the available budget clearer and to support more flexible planning
- tracking the data: one local authority showed that packages of care cost 50% more per week when they moved from a direct payment to commissioned care after having a small increase in their budget refused
- creating a self-employed or micro-provider rate to encourage use by people with lower levels of need and smaller budgets, while helping to grow that market.

Improving PA recruitment

Ideas and activities we heard about:

- using social media for recruitment, including local Facebook employability groups
- tracking which recruitment routes bring in new PAs
- using introductory agencies and micro-providers to help supply PAs.

Promoting direct payments more effectively

Ideas and activities we heard about:

- making the benefits clear, including through testimonials from people who say that direct payments have been life-changing
- making the process feel less daunting – for example, through videos explaining what support is available and how people will be helped through the process
- raising awareness early through places such as GP surgeries, libraries and colleges
- using videos in different languages to broaden reach
- balancing lists of restrictions with more examples of what people can do with a direct payment
- using reablement as a point to introduce and set up direct payments
- changing website language from responsibility and burden towards support and practical help.

Ambitions for the future

Ideas and activities that staff wanted to do:

- investing more in user-led organisations and peer support
- removing the requirement to get funding authorisation below a set threshold, and trusting qualified social work practitioners to agree packages up to that amount
- digitising the administration behind direct payments – for example, to manage money flows more easily
- automatically uplifting budgets in line with minimum wage changes
- trusting professional judgement and removing layers of authorisation to make direct payments more attractive to the workforce
- creating a dedicated specialist social worker role within the direct payments team to resolve problems quickly, support other practitioners, and streamline reviews and decisions.

Our research clearly shows that local authorities are putting in substantial efforts to increase the quality of direct payments, as well as the number of people who use them. In the next chapter we look at how staff across the five local authorities experience efforts to improve direct payments and where they think the barriers and opportunities exist.

04 It’s not easy to set up direct payments

Given that many of the people eligible for social care don’t know about direct payments, or have limited understanding of how they work (Needham 2024; Dunnion 2023), direct payments may not be part of the discussion if they aren’t raised by frontline workers. We heard repeatedly from people in all roles – leadership, commissioning and finance, as well as frontline staff themselves – that social work practitioners are not sufficiently confident or knowledgeable about direct payments to offer them as a positive choice. The answer, for many, lies in upskilling social work teams through training, reflective practice and other processes. However, our interviews showed that the factors behind decision-making during the critical initial interaction between staff and people eligible for adult social care are complex and unlikely to be resolved by frontline staff training alone.

Knowledge, skills and confidence among frontline staff

We heard clear and consistent recognition from those engaged in the initial decision-making process, as well as from their colleagues across the system, that frontline workers often don’t have the technical knowledge, skills and confidence to offer direct payments in a way that makes them attractive to social care users. Direct payments are not included in the national curriculum for social workers, and in-house general training is wide-ranging, leaving little time to focus specifically on direct payments. Frontline workers reported that they can often go months without processing a direct payment, which means they do not develop familiarity and confidence in the processes that might come with frequent and repetitive handling.

The local authorities involved in our research have implemented a range of responses, including targeted training, direct payment cafés or other drop-in facilities, peer support, and direct payment champions in social work teams. Without clear direction on ‘what works’, these ideas are often implemented as pilots or trials as staff with responsibility for leading direct payments aim to gain insight alongside frontline staff learning. Although we heard enthusiasm from direct payments’ leads for keeping these efforts going, often we also heard uncertainty about what works best (or what doesn’t work) and why. For example, more than one of the people in leadership positions that we interviewed questioned whether targeting training at specialist teams would be more efficient than providing it more broadly.

These practical initiatives are generally well-received and are recognised by those who experience them to be useful and effective for resolving queries. However, some frontline staff expressed uncertainty about why direct payments were suddenly getting so much attention from leadership within their local authority. This suggests that more work may need to be done by

programme leads and wider leadership teams to contextualise the various ongoing activities and ensure staff commitment to the wider vision.

Importantly, efforts to upskill frontline staff don't always lead to an increase in the number of direct payments being taken up, even if they are reported to have improved the quality of direct payments being offered and the experience of staff delivering them.

> *We set up the direct payments' hub, it didn't make a material difference, except that the qualitative information tells us that practitioners like it, families seem to quite like it, something good happens. But we can't really measure that in more direct payments.*

Workload and capacity to set up direct payments

Regardless of role, interviewees recognised that setting up direct payments takes a lot more time for frontline staff than referring people to commissioned care. Moreover, we heard that the time demand is only growing as the lives and needs of people drawing on social care, and of the families and wider networks that support them, have become increasingly more complex.

None of the frontline staff interviewed said that workload directly prevented them from offering direct payments, but they consistently raised concerns about capacity and the need to manage direct payments alongside their other responsibilities. It is perhaps inevitable that time pressures increase resistance to offering and promoting direct payments. This capacity problem is widely acknowledged by local system leaders.

> *What I'm hearing, sort of, on the grapevine, is that the pressure is even more intensified now... The pressure on practitioners, in terms of throughput, is more significant than ever.*

Local authorities have different arrangements for the point at which frontline staff hand off responsibility for setting up care arrangements to specialist direct payments teams. However, social work practitioners consistently report that setting up and managing direct payments is administratively complex. Processes such as taking support plans to approval panels often involve extensive back-and-forth between teams, adding to the time required for routine administration and creating further inefficiencies where communication between departments is poor.

Although our case study sites have locally specific arrangements in place to reduce the demands on social work practitioners (such as dedicated direct payment support staff, centralised, specialist social worker teams, and direct payments champions embedded in social work teams), both the expectation and the reality of immediate and longer-term time commitments is clearly off-putting to frontline staff. And this is recognised by those leading the process:

> *You're working with somebody, supporting somebody and you've got two options... You go through, Option A is a commissioned service that's already been done by*

> *commissioners, it's brokered, it's got a price, they can meet your need, you can start tomorrow. Or you've got somebody who's got to then be supported to go out and look around the market for a personal assistant, negotiate fees, help them set up, etc. The easier option is to go for the commissioned service, I'm afraid.*

Offering a direct payment is not a one-time opportunity

Often, social care packages are set up at 'crisis points' when an urgent response is required to meet essential needs. It was consistently acknowledged across our interviews that the process to set up a direct payment is too slow to respond to this immediate demand. However, it was also well-recognised that people generally remain with their initial social care set-up until it fails. This means that the opportunity to have a direct payment may never be raised for people who enter into the social care system at a crisis point, even if it could be a more appropriate mechanism for them over time. Given the volume of older people who enter social care at the point of hospital discharge, it is perhaps not surprising that direct payment uptake among this cohort remains low.

Interviewees told us that routine reviews of existing care packages do not examine whether there is scope for introducing a direct payment, such that anyone who starts out with commissioned care is unlikely to move over to a direct payment. This tendency towards unexamined continuity is exacerbated by social work practitioners being discouraged from the 'duplicative' activity of offering a direct payment when a commissioned care package is already in place. This results from the promotion of short-term efficiency over longer-term effectiveness, and relates to capacity and time pressure concerns already discussed.

> *It's a sense of maybe having to duplicate what you've already done, and then a reluctance to then go and justify this duplication of, you've already got a package of care, it's working, why would you bring in a direct payment at this point?*

Some of our local authority sites are specifically tackling the problem of people automatically staying on their original pathway by creating new points at which direct payments can be introduced. Strategies already in place or under consideration include: running a commissioned care package and a direct payment in parallel; using the six-week review of new care packages to revisit the option of a direct payment; asking brokerage teams to raise direct payments rather than automatically arranging commissioned care; and redesigning entry into the social care system so that direct payments are considered as part of triage.

Although many of these activities are too new to allow robust evaluation, they all break the cycle of a single decision point being automatically continued, which both introduces the possibility of increasing direct payment uptake and, in some cases, also shares some of the workload of introducing direct payments.

Creativity is worthwhile, but adds complexity

One of the key advantages of direct payments is their scope to allow the design of creative packages tailored to meet individual needs, and frontline staff consistently told us that they had the autonomy to exercise that creativity. However, leaders recognise that implementing creative responses isn't necessarily easy, or normalised.

> *Do I think honestly that our staff can currently create really creative…? No, I don't think they can… I have never seen anything very creative around direct payments.*

We got the sense across our interviews that while the idea of developing creative responses to meet individual needs is something that people are genuinely receptive to, an understanding of quite how that gets embedded into practice is less well developed.

This is backed up by evidence from frontline staff. They recalled, with pride, examples of innovative, tailored responses that met people's specific needs, such as funding a gym membership or supporting someone to volunteer at some stables. However, they were also quick to tell us about barriers that, in practice, limit their capacity to be creative. Middle management were often cited as blocking creativity through lack of awareness of the objectives of direct payments or fear that innovative expenditure wasn't a suitable use of public money.

> *I've just recently set one up for something and my manager said to me, 'I don't know how to do that...' If somebody as a social worker then develops into, goes to be a manager, but has never really done any direct payments, there's not going to be a push for it.*

Some frontline workers feel that they have to 'sneak things through' to avoid the scrutiny of review panels, and multiple other layers of approval, which are already recognised as daunting and intimidating processes.

Despite the barriers, there are reasons to be optimistic. In one site where leadership have consciously tackled these problems, they are starting to see real change:

> *We're seeing packages for people using local gyms, but having memberships to different places, using different bits of tech, having different apps. So, we are definitely seeing much more creativity and flexibility and I'm slowly getting fewer requests to come and deal with management. So, that would suggest to me it's getting easier.*

05 Social work practitioners receive conflicting messages about what's important

The issues raised in the previous chapter appear, at first glance, to refer only to practical matters about when to offer direct payments or how to make them most attractive to people who draw on social care. However, they also reflect the challenges that frontline staff experience of being asked to promote direct payments in a system that may not encourage their use.

We heard that, in practice, social work practitioners are expected to advance personalisation and increase uptake of direct payments while also moving people quickly off waiting lists, ensuring that needs are met safely, and demonstrating that public money is being used efficiently. These different sets of objectives are often contradictory and the resulting, unresolved tensions can land on frontline staff. Where these tensions aren't worked through, uncertainty often prevails. Decision-making is often left to individuals when there is a lack of a shared consensus that underpins a consistent approach. This also means that staff can't be confident that risks are shared and based on an agreed approach. Instead, frontline staff often feel that risks fall on them as individuals. How different local authorities respond to supporting frontline staff around these tensions will affect local uptake rates.

Two areas in particular where we found social work practitioners filling the gaps – and holding very diverse views – were around who would benefit most from a direct payment and how cost effective they were.

No agreement on cost-effectiveness

It might be expected that local authorities would have a clear sense of the relative cost of direct payments compared to commissioned services. Yet we found no such clarity. For some, direct payments were assumed to be cheaper than commissioned care, while others thought there were no cost savings to be made.

In principle, direct payments are often seen as having lower overheads than commissioned services. We were told that when individuals are trusted to make their own choices, they often want less for themselves than professionals think. Several interviewees also suggested that a system based on trust should be cheaper than one based on mistrust and excessive monitoring. In one area, the case for change was made using financial data, pointing to instances where people who moved from a direct payment to a commissioned package – often because an uplift was refused – ended up costing the authority around 50% more per week.

Others felt that direct payments are not necessarily cheaper when PAs are paid at rates that reflect the real living wage or above, as well as employer national insurance and pension contributions. If a direct payment is used to purchase care from an agency, this can be more expensive than the local authority commissioning it.

Interviewees recognised that the objective of direct payments is to increase choice and control, and it is no surprise then that we found a tentativeness around the pursuit of cost savings through direct payments:

> *We don't want to promote direct payments because there is money to be saved but if we manage to have loads of direct payments with people employing their own PAs, there would be money to be saved.*

Views differ on who should receive have a direct payment

Although frontline workers consistently expressed the belief that direct payments are 'a good thing', we often heard qualifications regarding who they are good for, with implications for who does or doesn't get offered one. Again, in the absence of a shared and widely agreed view, frontline staff pre-conceptions about who direct payments are suitable for shape practice.

However, perceptions aren't consistent in terms of strength of feeling, between places, or between staff within places. For example, more than one person suggested that those living with mental health difficulties would be less likely to have capacity to manage a direct payment. Meanwhile, others thought the flexibility of direct payments, such as the ability to use them for support to attend activities that would be otherwise inaccessible, makes them particularly suited to people with mental ill health. Similarly, we heard opposing views around the value of offering direct payments to older people. Some interviewees felt that direct payments are less suitable for older people, seemingly based on assumptions about their competency, and that their requirements centre predominantly on personal care rather than wider needs.

> *There's definitely a reduced uptake from the over-65 age group. And I think that's because people feel that there's, (a) less availability of services that they can use their direct payment for, and (b) people don't want the, let's call it hassle, of the admin, and the paperwork, and the management involved.*

These attitudes are held by people across different roles, not just frontline workers, which limits system checks on these perceptions and their impact on direct payment uptake. They appear to be largely unexamined, and are instead normalised as common sense, without much enquiry into the evidence behind the claim.

> *I think it is more accepted that a direct payment in the working age has greater value.*

There certainly didn't seem to be the same level of commitment to addressing uptake among older people as there is for those who are of working age. However, a conflicting experience suggests that these pre-conceptions may be doing older people a disservice:

If anything, I think the older people use it more than the young, in my experience... Because they want to know who's coming to their door.

Sharing systemic risk

Frontline staff told us about systemic problems that undermine the viability of direct payments for people who draw on social care. These include factors like deciding budgets based on a 'time and task' model that limits creativity, the absence of an adequately functioning PA market, and the amount of work involved in meeting scrutiny expectations. They also described internal factors that they feel make it harder for them to offer direct payments, such as processes restricting creativity (as already described) or problems associated with depending on commissioned support services that don't deliver consistently, increasing their workload as they pick up tasks not completed appropriately rather than leaving people who draw on social care to lose out.

We address these matters in further detail in the following chapters. However, as well as describing how these factors cause problems for delivering direct payments, frontline staff also pointed to how their knowledge of the system, its fissures and its potential for failure makes them reluctant to offer a direct payment. For example, one social worker said they felt 'like a little bit of a fraud' speaking enthusiastically about what direct payments can provide when they know that the budget won't cover what is being offered.

It is also apparent that frontline staff can feel that they hold this risk alone, rather than alongside middle managers in a system agreed with leadership. This is experienced within a larger system of communication where a leadership-conceived vision of direct payments and how they should be implemented does not always reach those on the frontline.

As senior leaders, there's such a gap between us and the frontline workers that our comms isn't going to scratch the surface, it's in the everyday behaviours of teams that it needs to be… that that's the behaviour that needs to change in order to see the difference. So, that's down to middle managers to implement.

This suggests that there is still much important work to do around organisational culture, especially in relation to developing consensus and shared views.

Frontline staff did not specifically tell us that the issues raised here prevent them from offering and promoting direct payments. However, they gave a strong indication that collectively, these factors cause sufficient friction that they can reduce the likelihood of a direct payment being offered. It is clear, then, that increasing the knowledge and skills of frontline staff is not sufficient on its own to increase direct payment uptake, given all the other systemic barriers identified.

06 Support to manage a direct payment is often accepted to be inadequate

Many senior leaders admitted they had limited insight into people's day-to-day experiences of using a direct payment locally but nevertheless recognised that the way they supported people to manage their direct payment was often inadequate.

No consistent model for direct payment support

Some areas had in-house direct payment teams that provided set-up and ongoing advice; some contracted this service out to national or local providers, while others seemed to muddle through:

> *We don't have a direct payment support service – it was moved to external but we don't have one, don't have any information officers, we don't have a brokerage role for direct payments that looks at the different elements.*

In several sites, large national providers had won tenders to provide local direct payment support. Some staff were unhappy with this service and felt that support was better provided by user-led organisations that had local intelligence and offer peer support. Innovative suggestions on how to improve support included embedding specialist direct payment advisers within the local community rather than the 'bureaucratic' local authority infrastructure.

Limited support for decisions about whether to take up a direct payment

Supporting someone to make an informed choice about how they organise their care is a critical moment that shapes the use of direct payments. Some local authorities invested significant resources in trying to get this conversation right and giving people the information they need. One area, for example, directed people to the former social work practitioners who were specialists in direct payments to discuss their care options – each person got three to five hours of support before taking up a direct payment. In other areas, there was limited advice and guidance offered at this stage.

Some local authorities were putting effort into raising public awareness about direct payments, such as postcard campaigns in GP surgeries, libraries and community hubs. Others felt that targeted campaigns would be more effective – for example, focused on the transition to adulthood team or carer support. Two local authorities had also successfully worked with local

community groups and substantially increased uptake of direct payments among specific ethnic minority communities.

Although low awareness of direct payments among the public was identified as issue, it was not thought to be the key reason why uptake was low. Staff were acutely aware that direct payments can sound daunting and overwhelming.

The responsibilities of being an employer were considered by staff to be the most off-putting aspect of taking on a direct payment:

> *It's easy to say you have more direct payments because they give people choice and control, but they give people choice and control to take on a really potentially complex employment system that they have to navigate through as an individual.*

The level of support varied across the sites. People in one area, for example, would receive a check every six weeks for six months to make sure that a direct payment had been set up well and all the correct procedures were in place, such as employer's liability insurance. In other areas, commissioned support was only available to those who had opted for a managed service or wanted payroll support.

We also found wide variation in terms of individuals being able to choose their payroll provider. Some local authorities tightly restricted an individual's options, whereas another was actively trying to expand and diversify the direct payment support market following user feedback.

Across the sites, staff held clear ambitions to make direct payments easier to use and less burdensome. For many, this meant moving away from a transactional, bureaucratic approach towards one that was more relational. Leaders spoke about 'getting alongside' people to understand what matters to them, upholding people's human rights, building trust and confidence, and devolving decision-making.

07 The budget-setting process does not always support a focus on outcomes

We found that the way in which budgets are set and agreed is not purely a technical exercise. Instead, budgets are closely linked to staff perceptions about offering a direct payment – and their ability to use a direct payment to increase an individual's personalisation, choice and control. As such, the tools and processes used to calculate and agree budgets provide a rich source of insight when it comes to understanding variation across local authorities.

'Time and task' approach to budgeting

Most local authorities use a 'time and task' approach to calculate a budget. This approach is deeply embedded across all adult social care budget-setting processes, and direct payments are no exception. Under this model, a person's indicative budget is generated by breaking down their assessed needs into a list of care tasks (for example, washing or meal preparation), estimating the time each task should take, and applying a standard hourly rate. The totals are then added up to produce the personal budget.

Identifying a person's needs in terms of tasks and time may provide consistency and clarity for local authorities, but it can also restrict what care options are considered.

> *Nowadays everything's got to be costed to the penny... and it just doesn't feel that anyone's got flexibility if I'm honest.*

Social work practitioners reflected that, if applied rigidly, a task and time approach allows for little creativity or flexibility. Conversations become focused on tasks and services rather than outcomes.

Several local authorities revealed that they had tried alternative budget calculating tools, but with limited success. However, one of the case study sites had introduced a new budgeting tool to support outcome-focused direct payments. It was too early for them to assess the impact, but most staff felt it was already helping to shift practice (*see* Box 1).

> *It's a real shift between, right, I've been out and assessed this person and they need breakfast, lunch and tea visits, to thinking, actually, what does this person want to achieve and giving them the flexibility to do that.*

Personal assistant rates as a source of confusion and frustration

Across the case study sites, we found markedly different approaches to setting hourly rates for PAs. Indeed, the hourly rate paid by a local authority for a PA was a hotly debated issue and one that was often a source of both frustration and confusion within both social work and finance teams. It was also an area where staff would welcome more guidance.

In some areas, the PA rate was set lower than the commissioned care rate, whereas in others it was set higher. Some set a fixed standard rate and others operate a tiered system with differential rates designed to reflect challenges in recruitment – for example, in rural areas or for people with a higher level of need such as autism. Negotiating a higher rate than the standard hourly pay was often felt to be more time-consuming and stressful for social work practitioners compared with commissioned care where the rates are already agreed.

The issue of what to pay a PA is further complicated for local authorities because the person employing a PA via a direct payment should, in theory, be entitled to set the salary, and not the local authority:

> *It's not up to us [the council] to dictate the rate that a person pays a personal assistant. Because if you go with the spirit of direct payments, they're given a budget and they're allowed to manage that budget how they see fit, provided it meets their intended outcomes.*

In reality, for some direct payment users, employing a PA of their own choice meant only being able to do so on reduced hours, or having to top up the budget, or asking family members to fill the gaps.

Getting approval for a personal budget

Some local authorities had introduced multidisciplinary panels as a way of encouraging greater diversity in budget-setting and constructive challenge. These are designed to ensure consistency and fairness and to promote the use of a direct payment if it hasn't already been considered. However, in practice, social work practitioners often experienced these 'Dragon's Den'-like panels as an interrogation rather than an innovation designed to promote uptake or personalisation:

> *Even when you do finish a good bit of work, you then have to go to these panels, as I was saying, and it's a kind of, Oliver Twist type moment – your hands cupped, 'please Sir', you know. And then sometimes you walk away from that with more work.*

Middle managers on these panels were named as a barrier to getting more creative budget requests approved. This is just one area where middle managers were identified as sometimes operating as obstacles to a creative approach.

Direct payments affect how individual contributions are collected

In line with the way all adult social care is assessed, people may have to make a financial contribution towards the cost of their care. Although the level of contribution remains the same whether a person chooses direct payments or commissioned care, the way it is collected differs. This has practical consequences both for individuals and the staff responsible for collecting the money.

An individual with a direct payment, and making a financial contribution towards their care, will receive their budget with their contribution already deducted. This means, in practice, that if care costs increase, someone using a direct payment could be left unable to cover the full cost of care. In contrast, someone receiving commissioned care will usually pay their assessed contribution to the local authority by direct debit or an invoice. The council would normally pay the cost increase for someone receiving commissioned care.

However, for some individuals with higher levels of income or assets, the level of assessed contribution effectively ruled out a direct payment as a viable option.

> *If that client contribution towards their care is high, but the care package that's in place is only, say, for three hours, their client contribution might mean that they will pay the whole cost of that care, anyway. So then they can't have a direct payment, because in effect, we would be doing nothing.*

In these situations, there was an assumption that local authorities would arrange the provision and invoice the client for their contribution. Interestingly, one of the case study sites did support self-funders ineligible for direct payments – for example, with guidance on how to employ a PA.

Individual contributions to top-up budgets

In addition to the financial contributions people on direct payments are required to make, some also choose to top up their budgets. This allows people to pay more for a PA or a service than their allocated budget fully covers. For others, however, it is effectively a choice between topping up the budget with their own money or reducing the hours of care they receive. One social worker described how the gap between the promise of choice and control and the reality of insufficient budgets left them feeling, in their words, like 'a fraud'.

Social work practitioners in some areas reported that an individual's personal budget was sometimes insufficient to meet their needs. It did not adequately cover the hourly rates to recruit a PA or to cover bank holidays or evenings:

> *To make the direct payment work, they had to basically say, 'Well, my family will cover on a Sunday so that I can have enough funds to have it for six days.' I know they needed it for seven, they need support for seven, but it [the direct payment] wasn't going to cover it.*

There is not always clarity about contingencies

Some local authorities routinely gave people a contingency to cover emergencies or unexpected events such as finding cover for a PA. It was sometimes left to the discretion of the social work practitioner. However, it was clear from the interviews with people using direct payments that information about a contingency was not always communicated or explained.

For people with larger care packages, it was sometimes possible to build up a contingency of several hundred pounds a week. For those on smaller budgets, this flexibility was largely out of reach. In practice, we were told that a direct payment covering less than 10 hours a week left little or no capacity to either build up a contingency pot or to absorb unexpected costs.

While often opaque, the tools and processes used to determine and approve budgets are important in shaping direct payment practice. They deserve greater interrogation and understanding. We turn next to what happens once the budget has been handed over in terms of scrutiny and monitoring.

Box 1: Budgeting for outcomes

One local authority that was implementing a new outcome-focused approach was clear about the steep challenge it faced in 'weaning' staff off a time and task approach to budgets. It hoped that the introduction of a new outcome-based budgeting tool would accelerate change.

Instead of a budget that dictates hours of care needed, social work practitioners were presented with an indicative whole figure sum that had an upper and a lower limit. The lower limit reflects a PA rate and the upper limit the cost of a commissioned care package. This flexibility was designed to encourage staff to be more creative in identifying diverse ways of allocating the budget to support someone's desired outcomes.

Also key was being explicit that direct payments were a central element in the adult social care budget.

Having direct payments as a key bit of our budget build has helped. People know there is a budget there for that and they know the parameters [in] which they can operate within those spaces. That wasn't the case pre-2023, we didn't have that set up in that way.

We heard a genuine sense of excitement about what this approach could deliver, but we also heard concerns about the lack of clear operational guidelines. This may have reflected the timing of our research and the fact that this approach was in transition. Nevertheless, interviewees from across the council highlighted how much of a shift this approach represents to established ways of working – for example, would the council be able to have effective scrutiny and oversight?

Whereas before it was us saying to them, well, you can have this support, that support, or you could find a PA, but now it's just leaving it to them. But again, I think we might have a few stumbling blocks because that's going to be overwhelming for people. Especially people coming into social care. They don't really know what is out there that they could access, even with a direct payment.

08 Local authorities face a difficult balancing act in the amount of scrutiny they provide

Local authorities face a difficult balancing act when it comes to deciding what's an appropriate level of scrutiny for direct payments. On the one hand, they have a responsibility to ensure that taxpayers' money is spent appropriately, and on the other, a desire to give people the freedom to choose how they spend it.

In practice, local authorities manage this tension in different ways, adopting slightly different approaches to oversight.

Substantial machinery exists to ensure money is well spent

Audit teams for direct payments were well-established in all the case study areas, and significant resources were devoted to monitoring how direct payments were used. In one local authority, for example, up to five monitoring officers oversaw around 800 cases.

> *We have massive internal audit teams who go looking and lifting up stones everywhere because we worry about fraud. We spend a lot of public money… any hint of that being mismanaged or mis-spent is something that local authorities worry about enormously. And I think direct payments get caught up in that space.*

The frequency and intensity of scrutiny varied, with some local authorities carrying out quarterly financial reviews and others relying on six-monthly checks. In several areas, low-risk and well-established direct payments were moved to annual (or even biennial) reviews, and some authorities audited only a sample of lower-risk cases.

Misunderstanding is thought to be a bigger issue than deliberate misuse

None of the people we spoke to thought that there was a high level of deliberate fraud or misuse of public money by people using a direct payment. Where there was misuse, it was often attributed to a misunderstanding of the requirements of direct payments (such as accurate record-keeping) rather than deliberate fraud.

Staff also recognised that issues flagged through audit were often caused by system failures rather than intentional misuse. For example, delays in completing a needs assessment could

mean that financial and care assessments fell out of sync. As a result, some people were left trying to manage their direct payment with a budget that no longer matched their needs, which could lead to arrears and significant debt accumulation.

In some cases, penalties for mismanaging a direct payment were swift and severe:

> *If you don't provide the documents after six months and then annually thereafter the direct payment will be moved to a holding account or it might be suspended or it might be replaced with a commissioned service.*

In one area that had seen a small increase in the misappropriation of funds, one interviewee suggested this may have been linked to cost-of-living pressures for disabled people. In some cases, this meant that people used their direct payment to cover essentials, leaving them without enough budget to pay their chosen care provider.

Staff think that people using a direct payment worry about spending it wrongly

Whether intended or not, staff also recognised that for some people the fear of getting it wrong prevented them from fully spending their budget. They also recognised, somewhat ironically, that the activities people might be most worried about paying for, such as social activities or sport, were precisely the things that might help them best meet their outcomes:

> *I think people get very anxious about if they've just spent it on, I don't know, going swimming or a bus fare... People worry about should they have spent it on that because it's us paying for something that isn't a social care need.*

When people are afraid to spend their direct payment, unspent money can build up quickly between reviews, as outlined in the previous chapter. Large balances can also accumulate when people cannot recruit a PA or find an appropriate care agency. Whatever the cause, the scale of clawback of unused funds surprised us. Local authorities were recovering or reclaiming large sums of unused direct payments – one reported having £6 million of unused funds that it was trying to reclaim. Staff recognised that this was an inefficient way to allocate resources.

In one local authority, the shift towards an outcome-focused approach was welcomed, but it also created anxiety about what it would mean for audit. Staff were unsure how to judge whether a person's budget was being used effectively against agreed outcomes, tasks or activities:

> *I think they sometimes approach service users and say 'Actually, you've purchased a bed with this money, that wasn't what that was on the care and support plan, you need to reimburse us...'. That's going to go out the window a little bit because we're coming to this ethos, 'well, this is the budget and it's down to the service user how they want to use that budget to meet their outcome', so it's going to be a bit more airy-fairy really, isn't it.*

Staff saw potential in digital change and noted the benefits of pre-payment cards in reducing the burden placed on people who used a direct payment. Digital was also seen as likely to change how scrutiny operates in future. For example, giving people who use direct payments access to an online portal could significantly improve both administration and oversight. It could also improve the user experience by allowing people to log in, view their budget and track transactions more easily.

09 Local authorities operate across different markets

There is only a small list of things that a direct payment cannot be used for. It includes food, clothing, NHS services, gambling, alcohol, anything illegal, and anything that doesn't meet a person's agreed outcomes. And yet, despite the apparently permissive nature of the guidance, direct payments are primarily used in two ways: to employ a PA or purchase agency care.

In this chapter we look at how local authorities are discharging their market-shaping duties, and the extent to which their approaches support a stable and affordable workforce, as well as meaningful personalisation. We focus on the different ways local authorities are supporting the direct payment market, which is largely made up of PAs, care agencies, family and friends as well as new entrants to the market such as micro-providers.

Shortage of personal assistants was a common problem

Employing your own PA has been a popular choice for spending a direct payment – and offers people a high degree of choice and control. The ease and speed with which someone can employ a PA is often taken as a strong indicator of how successful a local authority is in supporting direct payments.

The shortage of PAs and subsequent long delays to recruit one were a common feature reported in our interviews. These difficulties served as a significant deterrent for social work practitioners deciding whether or not to promote a direct payment.

> *You know, setting up direct payments for people would be an absolute breeze if there was this huge bank of PAs just waiting with capacity to support people.*

Notably, one of the five case study sites reported recent success with PA recruitment and retention. The direct payment team suggested that their work in this area meant they had become 'the public face' of direct payments, embracing social media, producing videos with clients, and building a much stronger connection with the local community. Systematic tracking also helped this team identify effective methods of recruitment:

> *So that's 35 PAs into jobs last month, you know, what we've been recruiting. So we keep the data on where did they come from – so did they come from Facebook, did they come from [a national online recruitment platform], so our digital platform that we invested money into, other family, friends.*

The ability to attract people to work as PAs is clearly linked to pay and, as we described earlier, how the rate of pay locally was determined remained an area of tension and debate. The

availability of the PA workforce was therefore closely linked to pay but also different local costs, particularly in rural areas, and different costs to reflect different care packages (and skills).

Local authorities differ in their commissioning strategies

Some people choose to purchase support from a care provider or agency via their direct payment. They may want to avoid the administrative burden of being an employer, find it difficult to recruit a PA themselves or want a particular care provider that is not on the council's provider framework and therefore not available via brokerage.

Interviewees questioned the relationship between the quality of commissioned care and direct payment take-up. In one area, staff wondered if their low rate of direct payments actually reflected the strength of the local authority commissioning, and asked whether neighbouring areas with higher rates of uptake were actually poor commissioners and 'forcing people into having direct payments'.

Micro-providers or community micro-enterprises are very small, local, community-based organisations designed to provide greater choice than traditional care services can offer. They also generate local employment opportunities. Interestingly, the role local authorities want these small care providers to play in the direct payment market, and the priority given to developing these organisations, varied markedly across the five sites.

One site had piloted an approach to encourage people who were already self-employed locally (for example, as handymen and women, gardeners or cleaners) to see if they could recruit them into social care as an add-on to what they were already doing. But they had limited success in attracting people to work in care. Having also heard from other councils that a strong micro-provider market could draw staff away from commissioned domiciliary care, the site decided not to pursue anything that might further destabilise the home care market.

In contrast, another site had invested heavily in supporting micro-providers as part of its wider strategy on place-based commissioning. Their asset-based approach had generated employment opportunities and lots of new providers. However, despite considerable investment, there had been very limited take-up of micro-providers by people using a direct payment. Interestingly, however, they had proved very popular with self-funders (*see* Box 2).

There is little consensus about which providers can be accessed through a direct payment

The way a local authority manages the market for direct payments is complex and intertwined with the adult care market as a whole. There is little written about how local authorities decide which care providers can be accessed through a direct payment, and yet this has profound implications for choice, control and personalisation in a local care system.

Even within our small sample of five local authorities, we found diametrically opposed approaches to provider frameworks. For example, one council was planning to severely restrict the number of providers on its framework, whereas another had few restrictions and felt it gave them greater quality assurance.

Several areas reported that they had used the framework to game the system in the past and artificially increase uptake of direct payments:

> *There was a lot of gaming. We gamed, and we gamed after other people when it became clear to us that other people were gaming. It was very easy to get everybody to have direct payments just by saying… you can only have this service if you have it through a direct payment.*

A popular and apparently well-used mechanism was to restrict the number of approved care providers that the local authority could commission directly to provide care. This meant that the only way an individual could use a particular agency that was not on the council's provider framework was to do so via a direct payment. Direct payments, in this context, were in effect used solely as a payment mechanism, not as a route to increase an individual's personalisation, choice or control. The numbers were significant, with one area claiming that more than 1,000 people switched from having a commissioned home care service to the same service via a direct payment.

The absurdity of people using a direct payment who were often not even aware they were using one was not lost on interviewees. These arrangements were viewed as offering neither greater personalisation nor cost savings, and several local authorities were now actively trying to identify people who had an 'inappropriate' direct payment and move them to commissioned care. This meant that individuals continued to receive the same service from the same agency – not via a direct payment but arranged directly by the council.

Decisions about whether micro-providers go on a provider framework also have knock-on effects on the use of direct payments. Micro-providers are often seen as a way to boost the options available for use with a direct payment. However, some local authorities have not restricted access to those with a direct payment. They have opened up their framework and allowed people to access this type of care via brokerage:

> *In terms of our micro-market, in theory anybody who wants to come and open up a business in [PLACE] can come and do that in that market. So, again, why would you need direct payments is the challenge there.*

Putting micro-providers on the framework was seen as a way to provide more personalised care without requiring people to take on the burden of direct payments. It enabled people to access local support from the same person, at times that suited them, offering the flexibility and continuity that people consistently say they value.

Other sites were exploring more radical ideas, including a 'commissioning for all' approach, shaping the market generally, not just for those that met the threshold for publicly funded care.

Although in the very early stages, it was discussing how such an approach could strengthen prevention efforts and increase creativity in the direct payment market, particularly for older people.

> *People who are not getting good value are buying very traditional care and then depleting their funds and then coming to the local authority for funding… I think that would be one of the things that would change this, looking at the whole of the population rather than just direct payments for those people that generally are coming to us.*

This was seen as a way to potentially encourage more micro-providers, particularly in very rural areas, to see care across all groups as a greater market opportunity.

Box 2: The relationship between community micro-providers and direct payments

One of the case study sites had invested heavily in micro-providers and illustrates how market-shaping can impact on direct payments.

Having seen the value of small, grassroot community organisations during the Covid-19 pandemic, the council was keen to take an asset-based approach to shift resources to support them. This work aligned well with its place-based approach to commissioning and an emphasis on social value. The micro-provider market grew substantially and attracted about 100 new people into the care workforce.

However, despite the growth and popularity of these small community agencies (particularly among self-funders and in preventive services), very few people who were eligible for publicly funded social care used a direct payment to access support from a micro-provider. As one commissioner reflected: 'We've ended up with a situation where we've developed community micro-enterprises but we're not seeing the benefits for the local authority for that investment.'

Given the level of investment, the local authority was keen to sustain this market and increase uptake among people receiving public funding. It focused efforts on strengthening brokerage support and widening its self-directed support offer to include individual service funds (ISFs). Individuals could now access organisations that were not registered with the Care Quality Commission (CQC). Under this model, micro-providers could also support individuals using a direct payment to explore their care options and manage their budgets.

Using the flexibility introduced by the Procurement Act 2023, the council also enabled micro-providers to become 'trusted provider'. As such, an individual could access this type of support as a self-funder, through provision arranged by a social work practitioner, or via an ISF or direct payment. Although this increased the visibility and use of micro-providers, it also discouraged some social work practitioners from promoting this option via a direct

payment. As one interviewee explained: ‘Why would I make myself and the client loads of extra paperwork if I can just commission it, like I would any other care?’

Part 3: What explains variation in uptake?

We were asked to explore why the use of direct payments is declining, and why rates vary so widely across local authorities in England. Based on interviews with council staff and people who receive direct payments in five local authorities, we found substantial differences in how direct payments are understood, supported and administered from one area to another.

The previous chapters have set out the main ways in which local practice differs across local authorities. Here, we reflect on what is driving this inconsistency. We also share our thoughts on what might be constraining local authorities' ability to shape practice and maximise how direct payments help meet people's needs.

What explains the variation in uptake and inconsistent practice?

Before we explore what might be driving variation, it is important to understand – and add a note of caution about – the data currently used to measure direct payment uptake. Data about the number and percentage of people in each local authority who received their care and support through a direct payment is published as part of the Adult Social Care Outcomes Framework (ASCOF) (DHSC 2025a, 2025b) and Adult Social Care Activity and Finance Report (ASC-FR) each year (DHSC 2025c).[1] A summary of the national trends and local variation in this data is provided in the introduction to this report.

It might be expected that local authorities putting the least effort into improving direct payments would have the fewest people using them. However, in our small sample of five local authorities, this was not the case. There was no obvious relationship between a local authority's reported efforts to improve direct payments and the number of people using them. One of the more active local authorities we spoke to also had the fewest number of people using direct payments. This suggests that the ASCOF data may not help identify the most progressive local authorities when it comes to implementation of direct payments.

Crucially, the number of direct payments is not necessarily an indicator of their quality – the extent to which the user has choice and control over their support. It is possible for a local authority to have a lot of people using direct payments who experience a high degree of dissatisfaction with them: they may, for example, continue to use them because it is the only way to retain services from a provider that is no longer on the local authority's framework agreement.

[1] For simplicity, and following convention, we refer to administrative data on direct payments collected from local authorities as ASCOF data. In practice, this data is a combination of that reported through ASCOF and ASC-FR.

Indeed, it is possible to manipulate the ASCOF data to boost the numbers using direct payments, and local authority staff were candid about this:

> *… we only had preferred providers on our dom [domiciliary] care contract and anybody who wanted dom care from anybody else, we made them take a direct payment to do it to try and boost our direct payment numbers a little bit... We were massaging the figures. You said it [the interview] was confidential, but I would say it publicly anyway, as I know almost everybody else is. I am not saying anything that isn't. Some will admit it, some won't admit it. I am just quite straight up, I will admit it.*

This strongly suggests that the ASCOF data is not an effective way of gauging the number of 'genuine' direct payments provided by each local authority.

We also heard, especially from senior leaders, that CQC scrutiny – and the consequent potential reputational risk – had been a key driver of local authorities' focus on direct payments. Several areas had prioritised work on improving direct payments in anticipation of a CQC visit. Understandably, there was concern that the CQC would take the nationally collected data as a proxy for quality. In some cases, at least, a robust challenge from the CQC on low uptake of direct payments had led to a constructive discussion about the local authority's approach to – and prioritisation of – delivering genuine, quality direct payments.

Different local contexts

Each local authority has unique population, geographical and cultural contexts, including a history of disabled people's activism, which shape how direct payments are implemented. We also found other factors that appeared to have a strong influence on local practice:

- Staff often ascribed renewed improvement efforts to a change of leadership – in particular, the arrival of a new director of social services, with a new vision and experience of direct payments in another authority.
- Wider local strategic aims and priorities also acted as a catalyst for action on direct payments, such as a focus on prevention or local growth economies.
- Co-production set the pace of improvement activity in some areas. One local authority was clear that it would not make any structural changes to direct payments until it had a better understanding of what local people wanted – they were letting 'co-production do its thing' before agreeing action.

Different delivery models

Local authorities use different models of delivery for direct payments, and this is perhaps one of the best illustrations of how a lack of evidence leads to variation in practice. Staff hold opposing views about, for example, whether it is more effective to set up dedicated, specialist direct payment teams or to encourage all social work staff to develop expertise in direct payments. In many areas, staff situated in finance teams regularly offer advice on direct payments to colleagues, deliver the training, and often develop closer and more continuous relationships with people who use direct payments than social work practitioners do. Our research does not

provide the answer, but it does suggest that staff need access to trusted expert advice on direct payments, and this is not always available.

We found marked variation in how local authorities provide support for people using direct payments. In some areas, local authority-commissioned provision from large national organisations is limited to administrative functions such as payroll and support with employing a PA. Elsewhere, councils invest in locally rooted, community-based support, including peer networks that can help people at each stage of the direct payment journey, from initial decision-making through to ongoing management. Ironically, many people using direct payments described developing significant expertise in navigating the system themselves and, at times, feeling more knowledgeable than the professionals supporting them. They also reported that access to user-led peer support had reduced over the years.

What is driving the disinvestment in locally commissioned support for people using direct payments is unclear. We heard leaders state how important it is for people to have access to timely, accurate and expert advice, particularly from peers, and some regretted not being able to fund this work within their current budgets. It therefore seems likely that disinvestment in locally commissioned support is due to financial pressures, alongside a wider disinvestment in the local voluntary, community and social enterprise (VCSE) infrastructure, rather than a belief that peer support isn't valuable or necessary.

Differences in understanding

Frontline staff make decisions about who should be offered a direct payment and what should be included in that payment. They make these decisions based on their perceptions and judgement, rather than clear criteria or robust evidence. When frontline staff, managers and finance teams hold divergent views, it builds inefficiency and friction into the process through initial hesitancy, duplication of activity through checking mechanisms, and redoing work following disagreement between and within teams. This has a knock-on effect and contributes to reluctance among staff to offer a direct payment.

Local authorities have a degree of flexibility over how they implement direct payment guidance. This can lead to very different approaches, and knowing when a person can use direct payment to employ a partner or spouse or family member that lives with them is a good example. Decisions on whether to pay family members are often not clear-cut. One interviewee described sometimes fraught situations where a family member felt the state should be compensating them for the fact that they were forgoing the opportunity to have an income and pension contributions. Another shared the dilemma of what to do when family members step in to provide a service that has been commissioned:

> *Sometimes we come to a review and we find that we've commissioned a care provider to take someone out shopping and then their niece has been doing for x time... Should we at that point be then offering the niece to pick it up and stepping down the care package a little?*

Others noted that some communities would welcome more flexibility over employing family members, and highlighted complaints about the use of male care workers to support women.

The prudent use of public funds is clearly important to staff in all roles. However, we found differences in opinion and, in some cases, real uncertainty about whether direct payments are cost effective. Although we heard the clear message that decisions around direct payments should be based on need and the right to personalisation, not the pursuit of cost savings, it would seem logical for cost-effectiveness to be an additional driver for increased uptake of direct payments. However, we heard very little on this across our interviews.

Different attitudes to money

The way personal budgets are calculated and agreed is not a purely objective technical or neutral process; on the contrary, we found evidence that it is highly subjective. As a result, the way budgets are set – and the way staff and people using a direct payment experience the budget approval process – offers rich insights into why and how direct payments vary across areas.

Direct payments are not simply a payment mechanism, they are a reallocation of decision-making power – and the ways in which local authorities choose to manage their relationships with people who use direct payments matter. We heard directly from people using a direct payment that, for some, the emotional, practical and financial burden of managing a direct payment was intense. For example, people held up reams of paper that needed to be uploaded to demonstrate that accurate records are kept. We were told about minute-by-minute activity that needed to be recorded to justify the budget. In some cases, it remained unclear how well staff understand the impact of this administrative burden and whether more needs to be done to ensure that people are well supported to manage their direct payment.

Clearly, budgets play a critical role in shaping practice, but we sometimes struggled to obtain a clear picture of how budgets are set. We might have asked the wrong questions or the wrong people, but we suspect that our lack of understanding of the ‘behind-the-scenes’ processes – the way a personal budget emerges or is calculated by a computer programme – is reflected in the experience of many of those trying to deliver direct payments, including social work practitioners.

The opacity of the system also impacts people using a direct payment, who we found to be often unclear on how much they had in their personal budget. Some were only told how many PA hours they had been allocated, for example. It is hard to increase people’s ability to personalise their care and choose what they want when they don’t have access to full information about their budget. Nor is it sustainable for people to feel they cannot be open about their situation. We also found high levels of fear among many of the people we spoke with – afraid that their budgets would be cut. This meant that people were afraid to ask for a review and were cautious about what they spent their budget on.

Differences in local system leadership

We recognise that work to improve direct payments is hard, often uncomfortable, and there is no blueprint. Leaders might find it helpful to recognise that some of the core elements of successful shared leadership are easy to identify when it comes to direct payments – and therefore have to be explicitly addressed early on. Any work to improve direct payments inevitably forces discussion – for example, on how best to tolerate uncertainty, share power, navigate conflict, manage risk, and invest in relationships that build trust across a system, including with people using social care (Walsh and de Sarandy 2023).

Uncertainty about what works, combined with a lack of shared agreement about what is right, creates a distinct challenge for leaders, and one that collective leadership is well-suited to tackle. We found that leaders, at all levels, were modelling new behaviours such as encouraging reflective practice and creating new spaces for managing conflict and shared decision-making. Staff were actively learning how to make decisions about direct payments when people held different professional and personal views.

However, we found that staff in every area did not always share an understanding of the purpose of reform. Frontline staff were sometimes unaware of the overall vision for direct payments, while senior leaders did not always have sight of how far that vision was translating into day-to-day practice. We found, for example, that some staff held the view that direct payments were only used when commissioned care was not a viable option – either because of the need for specialist support or workforce shortages in a rural location. This was at odds with the official view that direct payments should be considered as a first option for everyone, and used to increase personalisation, choice and control.

Local versus national systems of care

There are fundamental tensions built into our care ecosystem that limit local leaders' ability to shape direct payments. Our research suggests that even well-intentioned and often intensive efforts to improve practice can be constrained by wider system conditions. This means that improvement efforts do not always translate into higher direct payment uptake.

We suggest that the design and maintenance of the national adult social care system does not support local authority efforts to improve the quality of direct payments – and at times even undermines them:

- **The gatekeeping model:** direct payments are intended to give people greater choice and control, but currently, social work practitioners act as gatekeepers, and local authorities need to scrutinise their budgets. Social work practitioners decide what people need, and what level of support is required to meet that need, within a rationed system. These tensions are hard to resolve at a local level and are set out well in Glasby and Littlechild's (2016) review of direct payments and personal budgets.

- **System resourcing and organisation:** most resources in adult social care tend to be focused on the delivery of commissioned care rather than direct payments. Although local leaders clearly have power to manage their own resources, we argue that there are national influences on this too. Take quality assurance or the workforce, for example, where most resources are invested in supporting the care home/homecare market rather than PAs.
- **Pressures to maintain the current model of commissioned care:** several factors converge to work against shifting resources out of commissioned care to direct payments. These include: a desire to avoid any collapse in the commissioned home care market; not wanting to increase pressures on social work practitioners; concern over reputational risk; and, for some, a sense that previous efforts to improve direct payments have not worked.

We argue that the adult social care system is not currently designed in ways that consistently enable direct payments to work well. This raises a wider question about how far direct payments can be delivered within the current model of care, which we explore further in the final part of this report.

Part 4: Recommendations and implications for national and local leaders

With this research, we have tried to find out what sits behind uneven practice in terms of the delivery of direct payments across local authorities in England, and what can be done to improve both their uptake and their quality. Although we heard many practical examples of how people are improving direct payments, our recommendations do not focus on good practice. Our decision to make recommendations that might be harder to implement than specific actions, and perhaps harder to grasp and put into practice, reflects three things.

First, we believe that excellent guides and tools already exist (*see* TLAP 2026; LGA 2025) and can be easily accessed by any local authority wanting to know how to improve. Second, simply reinforcing the existing guidance is likely to have limited impact because we have suggested that direct payments are being asked to succeed in a system that is not designed for them**.** Third, this means that more of the same – whether it is better guidance or more training for staff – is unlikely to fix the fundamental problems with direct payments.

Instead, we set out our recommendations around three different frames and look at what national and local stakeholders can do to:

- improve the current system of direct payments
- improve the delivery model of direct payments
- improve personalisation, choice and control.

Stakeholders have a choice about where they place their improvement efforts. To be clear, we are not suggesting that local authorities should wait until the system is better designed, or that the DHSC cannot do more to hold local authorities more accountable for the delivery of direct payments. In this final chapter, we recommend that all three options are explored in parallel.

Improve the current system of direct payments

There is, without doubt, room to improve direct payments, and local authorities can take action in a number of ways, including:

- making it easier for people to choose a direct payment so they can make an informed choice (including access to peer advice)
- strengthening the ongoing support offer (so it does not feel like it is ‘too hard’)
- reducing bureaucracy and speeding up processes

- setting budgets and rates that make direct payments workable in the real world
- making monitoring proportionate and supportive (not punitive)
- shaping the local market so that people have real options.

However, none of these recommendations would be new or surprising to any local authority or to the DHSC. For example, it has been recommended for some years that local authorities should provide information in accessible formats or ensure that PA rates reflect actual employment costs (and include holiday pay, sick pay and pension) and local labour market conditions.

There is no lack of generic advice on how to implement direct payments better, whether that's through co-production or proportionate scrutiny. But for local authorities to see how well they are performing and understand what they should prioritise to meet local demand, they need systematic feedback loops that enable people drawing on social care in their area to share their experiences.

Develop an alternative measure of direct payments

As we have seen, ASCOF data on direct payment uptake is not a reliable indicator of direct payment quality. Additionally, it is open to gaming by local authorities. As such, ASCOF rankings should not be used to make judgements about the quality of direct payments or the effort being put into improvement. The priority now needs to be on outcomes and experiences, not just uptake, of direct payments.

We therefore recommend that:

- national and local leaders work together to identify how to routinely collect user outcomes and experiences, and use that data to systematically identify whether outcomes are being met, and for which groups
- although the CQC's focus on direct payments is welcome, more could be done to encourage transparency and explore the impact of gaming. The CQC's insights, alongside quantitative data, would provide a richer and more balanced indicator of quality than ASCOF alone.

Be braver

Brave national and local leadership is needed to champion direct payments and communicate their transformative potential. Leaders need to challenge the idea that direct payments are simply another way of delivering adult social care.

Although senior leaders did not express significant anxiety about having to defend more innovative uses of direct payments focused on wellbeing rather than personal care, we heard reservations from other staff about what direct payments could legitimately be used for. In our view, stronger leadership is more important than additional guidance if direct payments are to be promoted in the way described in the guidance. Similarly, both national and local leaders

need to be braver to successfully challenge the ageism that results in social care being defined as personal care for many older people, with the consequent risk that direct payments are seen as less likely to be suitable for them.

By developing consensus within local systems, leaders can remove – or at least share – the perceived risks for frontline staff that come with uncertainty about their own decisions and inconsistent responses from layers of management. Frontline staff must feel able to support creative and flexible uses of direct payments, in line with the guidance, even where this may seem unfamiliar or initially unacceptable to others. Our findings suggest that in this regard, national bodies have much to learn from local authorities that are doing this well through close involvement and partnership with disabled people who have lived experience of using a direct payment.

Be clearer about priorities

Although some stakeholders wanted new guidance, we remain unconvinced that stronger or clearer guidance would result in significant improvements. The Care Act 2014 and the Care and Support (Direct Payments) Regulations 2014 set out clear duties on local authorities to offer a direct payment to people who are eligible. As a result, there are clear expectations placed on local authorities. Instead, the focus needs to be on holding local authorities accountable for meeting those expectations.

Use of the CQC has been a particularly effective mechanism through which the DHSC has set clear expectations and, in our view, this could be explored further. The inclusion of direct payments as a dedicated area of focus within the CQC inspection framework has meant that local authorities have prioritised action and attention on direct payments in preparation for their inspection. It has galvanised action and sent a strong signal to local authorities about the government's priorities.

The DHSC needs to be more explicit that direct payments is an area they are scrutinising and prepared to invest in. One way of demonstrating its commitment is to support greater peer learning networks and commit to supporting requests for help and advice for issues that resonate nationally and emerge through these networks. Providing seed funding would also send a signal that direct payments were a government priority. Several leaders noted that small investments had been successful in the past in shaping the direct payment market – often with significant regional impact.

Provide better evidence on what works

Our research does not, and was never intended to, offer a single approach that will work for all areas, nor did we find evidence that this would work. Conversely, we found that local authorities need to develop their own bespoke approach and to assess how well they are working as a system to support direct payments. However, we do not think people who use social care are always well served by the variation that exists both across and within local authorities.

The lack of evidence to support practice is notable and it is understandable that staff start to fill these gaps in evidence or locally agreed responses with their own personal, professional decisions. Nationally commissioned research and subsequent guidance could help address these gaps in understanding and support better local decision-making in several key areas, including the following:

- Do you need specialist roles/teams?
- What elements are necessary to deliver personalised support to people thinking about choosing and then using a direct payment?
- Which budgeting tools best support personalisation, choice and control?
- When can you use a direct payment to employ a family member?
- How can artificial intelligence (AI) and digital tools support direct payments?
- Are direct payments more cost effective than commissioned care?

Adopt an explicit systems approach

A systems approach allows new questions to be asked about what might improve direct payments, and moves the debate beyond solely ascribing the problem to poor implementation alone.

Collective system leadership by national and local stakeholders depends on people being able to cultivate a shared vision as well as greater honesty and transparency. Steps to achieve this include:

- explicit inclusion of people with lived experience of using direct payments and recognition of their role and expertise as part of the system at both national and local levels
- stakeholders finding new ways to identify solutions to shared challenges, such as how to set guideline pay rates or ensure that social work practitioners receive training on direct payments and their benefits
- leaders spending time with frontline staff to understand what is needed to change practice and organisational culture.

Direct payments do not exist in isolation but are part of a complex and often confusing adult social care system. This means that no single organisation or professional group can address the challenges alone. In parallel, it also means that no single government department alone can improve direct payments. A cross-government approach is needed if direct payments are to be adopted at scale. Our research identified several areas where action from other government departments is needed:

- HM Revenue & Customs (HMRC) – the challenges of employing a PA are well-established and there have been repeated calls for changes to HMRC guidance to make it easier for someone on a direct payment to be an employer.
- The Home Office – decisions about international recruitment for care staff have excluded people wanting to work for an individual who has a direct payment.

- Department for Work and Pensions (DWP) – there are large numbers of family members who are unpaid carers. Some receive the Carer's Allowance but could receive more financial security by being paid via a relative's direct payment.

Consider alternative models of providing financial choice and control

As we saw in the Introduction, direct payments in their current form were introduced to improve, but not replace, a model of care in which local authorities act as 'gatekeepers' of public money – they assess an individual's needs, decide the level of funds required, and ensure that money is spent well. In most cases, local authorities still commission care on the individual's behalf; direct payments are therefore still the exception to a longstanding norm of how England 'does' social care.

National government should consider whether an alternative approach is more likely to deliver the degree of choice and control that many people want. It should consider the examples of countries such as Germany and Australia, where people in need of long-term care and support receive a budget based on their level of assessed need but have few, if any, restrictions on how they spend that money (closer to how the benefits systems operates in England than the social care system). Such an approach changes the relationship between the individual and the state, with a shift of power towards the individual. It would, however, involve a very significant change for the English social care system and to the role of local authorities, with much less scrutiny of public funds.

Take a broader approach to improve personalisation, choice and control for everyone

A key rationale for increasing uptake of direct payments is to strengthen the personalisation agenda and increase the choice and control people have over their care. However, direct payments are not right for everyone, and they should not be the only route for people to access high levels of choice and control.

Our research suggests that some local authorities are actively pursuing wider strategies to improve choice and control for everyone who uses social care—not only those using a direct payment. They are attempting to put in place support that replicates the good elements of a direct payment, such as being able to choose what times a person visits, being flexible about when care is provided and reducing the administrative burden on people receiving care. One good example to illustrate this shift is enabling people to access local, flexible support from a microprovider through commissioned care as well as via a direct payment. Other local authorities were adopting a more explicit strategy to invest in individual service funds as a mechanism to improve outcomes. An approach that focuses on improving choice and control for everyone explicitly supports improvements in the quality of direct payments, but not necessarily uptake.

Regardless of where national leaders choose to place the emphasis of any future work to improve adult social care, it is worth noting that there has been both the ambition and models agreed to deliver personalisation, choice and control for over a decade now, with limited success. Rather than doing more of the same, and expecting local authorities to implement the guidance better, there is an opportune moment now, given discussions about wider social care reform, to step back and understand how direct payments work within the current system.

An endnote of optimism?

It won't be a surprise that many people are unaware that direct payments are the government's preferred mechanism for delivering personalised care and support (DHSC 2014 a). Nor will it be a surprise that we found many examples of well-established practices and processes that do not support the concept of direct payments being a genuine way to promote personalisation, choice and control.

That said, this leaves a big opportunity for change, and we have been struck by the determination at all levels to improve people's experience of direct payments. Most striking was the generosity of people using direct payments, many of whom have spent years trying to improve direct payments yet are still willing to share their expertise and experience to make the system better.

National and local leaders now need to rebuild trust, model relational ways of working, and instil hope and optimism that social care can look and feel very different. They can show how direct payments can fit within a system of care and support, rather than be grafted on as an alternative service provision.

Annex: Methodology

This project comprised a Department of Health and Social Care (DHSC)-commissioned piece of research to assess factors affecting the uptake of direct payments across England and make recommendations for what the Department could do to support an increase in uptake.

The specific research questions were:

a) What factors explain the overall uptake of direct payments and the downward trend?
b) What are the reasons for variation in direct payment uptake across England?

To answer these questions, we carried out qualitative research in five local authorities.

The research was conducted in three phases:

1. Scoping and site selection – to support wider contextual understanding of direct payments, establish existing knowledge on challenges and opportunities related to implementing direct payments' policy, refine research instruments, and identify suitable case study sites.
2. Data collection – to identify the different ways in which direct payments policy is implemented in case study sites via interviews with local authority staff and people who draw on direct payments.
3. Analysis – to consider whether our findings on the different ways in which direct payments are implemented could explain the extent and variation of their uptake, and to make recommendations for local authorities and national government.

An advisory group comprising representatives from local authorities, the VCSE sector, and organisations that advocate for improvements in direct payments met three times during the project. The sequencing of research activities was such that the first advisory group meeting (used to get input into the research protocol, instruments and site selection) was held and ethical approval was gained during the scoping phase. Additional advisory group meetings were held towards the end of the data collection and analysis phases, to sense-check emerging findings and discuss analysis and recommendations, respectively. Ethical approval was provided by the University of York, and The King's Fund's standard quality assurance process was followed throughout the project.

More detail on each of the research activities is provided below.

Scoping

We carried out 11 scoping interviews designed to elicit insight on the intention, impact and implementation of existing national policy. Interviewees were drawn from existing networks,

advisory group recommendations and suggestions from other interviewees. They included key representatives from organisations that drive national policy and its implementation, and social care user and other advocacy organisations.

These interviews were supplemented with a preliminary survey of existing published findings on direct payments processes, which supported refinement of the research protocol and instrument, particularly towards avoiding duplication of existing knowledge.

Interviews were recorded but not transcribed and have been used for scene-setting rather than specifically included in our analysis.

Site selection

We developed a shortlist of potential case study sites drawing on intelligence gathered through scoping activities, including the first advisory group meeting, and responses to our advertisement of the project through DHSC, LGA and other networks. Our primary objective was to choose local authorities that between them reflected the full range of direct payment uptake rates, as indicated by ASCOF data. ASCOF reports the percentage of people who draw on long-term support who receive a direct payment by local authority; this ranges from 3% to 48%.

We ranked the full list of local authorities by their ASCOF figure and aimed to take a case study from each quartile of the rankings. For logistical reasons we ended up with a fifth case study site, with two sites in the lowest quartile and one from each of the other quartiles.

We have not assumed that each case study is able to ‘represent’ all other places within its quartile, but we wanted to use the research to consider the guiding assumption that uptake rates are a direct consequence of how local authorities implement national policy. Therefore, we needed to include local authorities with a range of uptake rates to be able to test this proposition, as well as uptake being a reasonable criterion to ensure we were working with a good range of local authorities.

As discussed in Part 3, we found that ASCOF data was not an accurate indicator of efforts to improve direct payments or of people’s experience of using a direct payment to gain greater personalisation, choice or control.

The additional criteria used to ensure site diversity were geographic and demographic, on the grounds that we assumed that these might impact how direct payments policy is implemented locally. We included city and county councils; urban, more heavily rural, and coastal sites; places geographically dispersed across England; sites with greater prevalence of older people (as direct payment uptake is lower among older people); and places with variation in ethnic mix.

Ongoing discussion with direct payment leads in potential sites meant that we were also able to do some preliminary investigation into the approaches used to improve direct payments and ensure that we included some breadth here also. However, we cannot claim that our sample is

representative, and we recognise that many other local authorities are doing innovative work on direct payments that our study has not captured.

Although a key objective was to maximise diversity of sites, it was also clear that we could only proceed with the research with the support of local authority leadership. In some cases, this required a fairly simple process whereby approval from the director of adult social services was managed by direct payments' leads, whereas in others, it required us to submit our research protocol for approval into a local research assessment process.

Research protocol and instruments

Drawing on insights from the scoping phase and an advisory group meeting, we refined the project plan and developed an updated research protocol to serve as the basis of the data collection phase.

The topic guide for the interviews with national stakeholders and with local authority staff in case study sites included questions in the following areas:

- local perspectives on variability in uptake of direct payments
- existing and possible future roles for central government in improving uptake
- the local vision for, and implementation of, direct payments policy
- the feasibility for delivery of genuine personalisation, choice and control through direct payments
- existing and possible future data and measurement systems for understanding whether direct payments policy is working
- what works well and could work better.

The topic guide for focus groups and interviews with people who draw on direct payment included questions and discussion around possible alternatives in the following areas:

- what people spend direct payments on
- the experience of processes designed to ensure direct payments meet needs: the original offer, ongoing support, review, etc.
- whether direct payments facilitate personalisation, choice and control
- barriers to having a direct payment.

Data collection

In each of the sites, we carried out in-depth, hour-long, semi-structured interviews with those leading improvements in direct payments (across adult social services, commissioners, direct payment, and finance and audit teams) as well those implementing direct payments. We held between five and eight interviews in each site, mainly with individuals, but there were a few occasions where two or three people in the same role were interviewed together. We requested

interviews with specific roles – director of adult social services, social work practitioner, and so forth – but the individuals involved were selected and agreed internally by the sites.

We also spoke to people who use direct payments or managed them on behalf of a family member in each of the sites. We planned these as focus group sessions, involving group discussion around specific themes and testing of preliminary hypotheses for how direct payments might be improved. In practice, we held focus groups in two sites and individual interviews in three sites. We had to adapt our approach because we became aware that people who were not genuine direct payment users were wanting to participate in the research in several areas. We took steps to prevent 'imposter' participants from contributing to the research, and this included moving from focus groups to individual interviews (see Medero *et al* 2025 for more information on this issue). Participants were recruited through local networks and social media, using a convenience (non-probability) sampling approach.

We interviewed 36 staff across the 5 local authorities and 19 people with experience of using or managing a direct payment in total. Given the small number of people being interviewed in each area, there are limits on what we can claim regarding representativeness.

Information sheets and consent forms were shared with participants, and they had a chance to ask questions before they gave consent. Informed consent was obtained before the interviews, focus groups and workshops. Participation was voluntary and individuals were free to withdraw at any point without consequence. All interviews were held online and were recorded with the consent of participants.

Anonymity

Although it means that we are not able to describe our findings in ways conventionally used for case study-based research, we decided to offer full anonymity to the case study sites on the grounds that participants would be more likely to feel they could be fully transparent about practices, decisions and perspectives if they were guaranteed confidentiality. For the same reason, although participating staff could not be anonymised within their local authority, they were made aware that we would not attribute any comments, ideas or quotes to specific roles. We did share with the direct payment users we interviewed that their local authority was one of the case study sites. However, we asked them not to share that information more widely and we did not divulge information that would enable people who draw on social care to attribute activities or opinions, beyond those already publicly known, to their local authority. Direct payment users were similarly assured that they were not identifiable to their local authority.

Analysis

Given the time lag between completing interviews with local authority staff and those with people who draw on direct payments, analysis started before the end of the data collection period.

Recorded interviews with local authority staff were transcribed in full. Several iterations of coding frameworks were tested by the research team prior to a final decision being made to label and annotate relevant excerpts of interviews. These were then analysed thematically and key findings that were considered to be additions to existing knowledge were summarised into chapters.

Focus groups and interviews with direct payment users were recorded and machine transcribed. Themes were drawn from re-listening to interviews and summarised into a single chapter.

The findings and analysis were tested with the advisory group and DHSC.

In line with our AI policy and transparency statement, we want to be transparent when AI is involved. In this research, AI (Microsoft Copilot) was used to help edit the written content of the final report. We asked it to make paragraphs more succinct and to improve clarity. AI-prompted revisions were not always accepted, and never without review. The King's Fund uses Microsoft 365 Copilot Chat with enterprise data protection, meaning that organisational ('work') data is encrypted, not used to train AI models, and remains subject to the Fund's existing security and audit controls. The authors retain full responsibility for the content, which was reviewed and validated prior to publication. The analysis and views presented are the authors' own.

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